

MEDICAL INTERVENTION HIT OR MYTH?

PART ONE OF A SERIES OF ARTICLES EXAMINING THE SAFETY OF
IMMUNISATION, AND VACCINATIONS.

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WARNING:

There are an alarming amount of people
who have died or who have suffered
serious adverse reactions to vaccinations.

Does immunisation really work anyway?

With strong moves now afoot to make
immunisation compulsory, before
children can attend school, these
questions must be answered soon.

The medical profession refuses to accept
any responsibility for adverse reactions
to vaccinations, to do so would raise
questions of litigation and liability.

This has meant that the only "tabs" being
kept on just how many people die, or
become 'retarded' suspiciously close to
a vaccination - is being kept by a small
bunch of dedicated parents in NSW.

If you would like to register such
information, contact:

**PARENTS CONCERNED ABOUT
VACCINATIONS**

PO BOX 900, KATOOMBA. NSW. 2780

THE MYTH OF MEDICAL ACHIEVEMENT

The first major challenge to the integrity of conventional medicine came in 1959 when Rene Dubos urged in his book *Mirage of Health* that the technological innovations of modern medicine, including the development of antibiotics, had far less to do with the improved health of the community than it might at first appear.¹ Amassing an impressive array of statistics in support of his claim, Dubos argued that the most significant changes in the health of the population derived from social, economic, and nutritional advances. Environmental factors not clinical care factors, were applauded as the primary determinants of the improved state of general public health. Better housing, for example, meant less overcrowding, thereby reducing the facility with which infectious disease was previously spread. Similarly, the provision of safe drinking water in conjunction with the treatment of sewerage dealt a forceful blow to infectious disease. Other environmental factors such as improved sanitary conditions and the effective disposal of garbage also had a beneficial impact upon the virulence and incidence of infectious disease. Heralded by some writers as the single most important factor in the decline of infectious disease, better nutrition has been acclaimed to assist host-resistance, as well as host recovery.²

Indeed, by the time the etiology of infectious disease was sufficiently understood to develop and to administer vaccines, diseases such as cholera, typhoid fever, and dysentery had already been robbed of their virulence. In his presidential address in 1971 to the British Association for the Advancement of Science, R.R. Porter confirmed that between 1860 and 1965 almost 90% of the total decline in mortality among children up to fifteen suffering from diphtheria, scarlet fever, measles and whooping cough had occurred prior to the introduction of antibiotics and immunisation on a systematic basis.³ The virulence of tuberculosis had also declined markedly prior to the introduction of antibiotics. In 1812 the death rate from tuberculosis in New York was estimated to be higher than 700 per 10,000. When Koch first isolated and succeeded in culturing the bacillus in 1882, the death rate had dropped to 370 per 10,000. By the time the first sanatorium was opened in 1910 the rate had further declined to 180 per 10,000, until shortly after World War II it had slipped from second to eleventh place with a rate of 48 per 10,000. Still before antibiotics were used routinely, tuberculosis had flourished and dwindled outside the control of medical science.⁴

This is not to say that drug treatment has been entirely incidental in the decline of certain infectious disease. Syphilis and malar-

ia were both quickly cured by chemotherapy. On the other hand, malaria has reappeared despite the continued use of antimalarial drugs, largely because the use of pesticides was eventually superseded by the evolution of pesticide-resistant mosquitoes. Syphilis strains resistant to penicillin have also returned to remind medical science that the interlink between mores and medicine are of fundamental importance in understanding disease patterns.

MEDICAL INTERVENTION AND IATROGENESIS

Iatrogenic illness refers to those illnesses which result from professional medical treatment, and which could presumably have been avoided had such treatment not been administered. Ivan Illich has done much to consolidate and bring into bold relief studies concerning this category of physician or hospital-caused injuries. He writes that "the pain, dysfunction, disability, and anguish resulting from technical medial intervention now rival the morbidity due to traffic and industrial accidents and even war-related activities, and make the impact of medicine one of the most rapidly spreading epidemics of our time."⁵ Illich claims that one out of every five persons entering a typical research hospital will acquire an

iatrogenic disease. Given that every twenty-four to thirty six hours, from 50 to 80% of all Americans will swallow a medically prescribed drug, it is perhaps unsurprising to find that one half of iatrogenic episodes arise from complications of drug therapy.⁶ Some patients are given the wrong drugs, others are given drugs which are contaminated. Some patients receive injections with improperly sterilised syringes, while others are given combinations of drugs which in their chemical reactions to each other prove to be harmful. The main problem here, however, is not simply one of negligence. Although the well considered and circumspect use of drugs may have a role to play in health care, chemotherapy is an interventionist technique whose importance and use has been greatly exaggerated. As Mendelsohn has put it:

"Unfortunately, doctors have seeded the entire population with these powerful drugs. Every year, from 8 to 10 million Americans go to the doctor when they have a cold. About 95% of them come away with a prescription - half of which are for antibiotics ... The doctor, once the agent of cure, has become the agent of disease. By going too far and diffusing the power of the extreme on the mean, Modern Medicine has weakened and corrupted even the management of extreme cases. The miracle I and other doctors were once proud to take part in has become a miracle of mayhem."

While there has during the past decade been a growing awareness of the limitations of drug therapy, the extent of the use and abuse of drugs in conventional medicine is still staggering. As a consequence of negative reactions to drugs, more than a million people every year, or 3 - 5% of hospital admissions, are treated for drug complications. It is also reported that 30% of these patients will experience a second drug reaction during the course of their hospital stay. The cost of health care associated with drug toxicity

in the United States is estimated at US\$3 billion yearly, and reflects the fact that 1/7th of all hospital days are required to attend to patients suffering drug reactions.⁸ Despite the growing use of street drugs, deaths attributable to medically prescribed drugs still exceed the number of deaths caused by the use of illegal drugs. It has been estimated that approximately 30,000 deaths per year are the consequence of adverse reactions to drugs prescribed by doctors. Serious reactions to drugs as common as penicillin, for example, occur in 5% of those individuals who are administered the drug. The anaphylactic shock which results from severe penicillin allergy is often more debilitating than the medical condition that the penicillin was used to treat. Clammy skin, profuse sweating, fallen blood pressure, cardiovascular collapse, and even unconsciousness are just a few of the side-effects of acute reaction to penicillin. During the 1960's the drug tetracycline was administered so frequently that it came to be called the "housecall" antibiotic, and a generation of children in America and elsewhere has suffered its adverse effects. In 1970 the U.S. Food and Drug Administration finally required that a warning be affixed to all packages of the drug, admonishing of the tendency of tetracycline to accumulate in bones and teeth.⁹ One of the more visible side effects of this chemical deposition has been to cause the permanent discoloration of developing teeth (ie stages of tooth development ranging from the last half of pregnancy to approximately 8 years of age). Countless adults now bear their "tetracycline scars" on their teeth in shades of discolored enamel ranging from yellow to yellow-green to gray brown.

Illich's study showed that one in every thirty cases of iatrogenic illness *leads to death*, and that the **frequency of reported accidents in hospitals exceeds the accident rates in all industries with the exceptions of mining and high-rise construction.**¹⁰ Of all children admitted to hospitals, one in fifty will suffer an accident for which specific treatment will be required.¹¹ In a study of medical malpractice conducted by the United States Department of Health, Education, and Welfare, it is reported that 7% of all patients suffer compensable injuries while hospitalised, though few of them take legal action. Nonetheless, it is estimated that in 1971 from 12,000 to 15,000 medical malpractice suits were lodged in courts throughout the United States. In a study by berman and Stamm on misdiagnosis, it was calculated that the number of children who suffer disability as a consequence of medical treatment for what turned out to be cardiac nondisease exceeds the number of children under effective treatment for genuine cardiac disease.¹²

In other cases it has been shown that specific forms of treatment actually exacerbate the specific condition they are intended to alleviate. The epidemic of asthma deaths in the mid-1960s provides a useful illustration. In England and Wales between 1959 and 1966 mortality due to asthma trebled in the age group 5-24 and increased seven-fold in the 10-14 age group.¹³ Up to this time mortality rates from this cause had remained relatively constant for more than half a century. Although the epidemic was shared by Scotland, Ireland, Australia, and New Zealand, asthma mortality in Europe, Japan and North America remained virtually stable. Once it was ascertained that the prevalence of asthma was not on

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the increase, investigators hypothesised that the epidemic of asthma deaths could be associated with the new forms of treatment whose introduction roughly coincided with the steady increase in mortality rates.

Evidence of the excessive use of pressurised aerosols containing bronchodilator drugs correlated with asthma patient deaths. Other investigations confirmed that the increase in asthma mortality correlated with the increased sales of aerosol bronchodilators, particularly those containing the drug isoprenaline. Additional evidence

in favour of the causal connection between the epidemic in asthma mortality and the excessive use of bronchodilator drugs came in 1968 when the sales of these aerosols were regulated in the United Kingdom by prescription. Within a year asthma mortality rates declined and levelled off to almost pre-epidemic rates.

Isoprenaline came under immediate suspicion since it was in any case

the drug mainly used as a bronchodilator in the 1960s, though considerable debate ensued as to whether the fluorocarbon propellant could be cast as the true culprit. Although both isoprenaline and the fluorocarbon propellants were demonstrated to produce heart irregularities, it has more recently been shown that asthma mortality correlates particularly well with the sale of bronchodilators capable of delivering up to five times the concentration of the normal spray of isoprenaline. It is estimated that in England and Wales the asthma epidemic claimed a total of 3,500 lives in excess of the expected rate over the same period calculated on the basis of the pre-epidemic rate in 1959-1960. It has been remarked by Taylor that, "even if some asthmatics were saved by medical treatment, more were lost."¹⁴

The use of other medically prescribed drugs has led to the increased risk of other diseases worse than the ones that they are designed to treat. Reserpine, for example, is one of the drugs which has been used to control high blood pressure. Despite the fact that studies undertaken in the mid-'70s have established that reserpine triples the risk of breast cancer, already ranked as the number-one cause of death in women, it is still prescribed. There are now indications that insulin, heralded as one of the miracles of modern medicine, is implicated as one of the causes of diabetic blindness.¹⁵ Investigations undertaken in the 1970s have revealed that daughters of women treated with a synthetic oestrogen, Diethylstilbestrol (DES), during the early stages of pregnancy for the purported prevention of miscarriage are developing vaginal cancer at an alarming rate. It has also been confirmed more recently that an alarmingly high incidence of genital malformations can be correlated with the male offspring of women treated with DES, not to mention that the cancer mortality rate of the women themselves is also statistically significant. Studies of DES have since established that it does not prevent miscarriage; indeed, it is in fact currently used as a "morning-after" contraceptive pill and in some cases to dry up milk. In the case of DES it is particularly ironic that here we have a drug that not only caused vaginal cancer and other abnormalities, but did not even work for the purpose for which it was originally administered.¹⁶

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DES is not the only hormone which - despite detrimental side-effects - doctors prescribe for women. While it is to be admitted that there has in recent years been a greater awareness of the drug-associated victimisation of patients to which we have been alluding, the fact that some 20 million women in the United States alone are under prescription for the birth control pill or menopausal estrogens gives cause for reflection. Concern about the side-effects of the pill led the U.S. Food and Drug Administration to issue a warning bulletin to doctors in 1975 exhorting that women beyond

the age of forty be taken off the Pill and provided other means of contraception. This first admonition was followed by a second from the FDA in 1977 requiring the provision of a warning brochure stressing the inordinately high risk of cardiovascular disease among women over forty taking the Pill.¹⁷ The mortality risk from cardiovascular disease for women over forty taking the

Pill is increased by *a factor of five*; for women between the ages of thirty to forty the risk of dying from a heart attack is multiplied by a factor of three. Increased risk of cardiovascular disease is not the only health hazard associated with the Pill. The risk of high blood pressure is six times greater for women taking the Pill than for those who are not. Women taking the Pill run a risk of thromboembolism which is more than five times that for women not taking it and the risk of stroke is four times greater.¹⁸ Other risks associated with the Pill are liver tumors, headaches, depression, and cancer.

Similarly, antihypertension drugs have in recent years soared in popularity as an easy way to lower blood pressure. Although medical journals carry advertisements for drugs intended to counteract the adverse effects of antihypertension drugs, sufficient awareness of their dangers seems decidedly not to be reflected by the astronomical number of medical prescriptions still written for them. Among the multitude of side effects associated with high blood pressure drugs are rash, hives, sensitivity to light, vertigo, muscle cramps, weakness, inflammation of the blood vessels, joint aches, muscle spasms, nausea, psychological disorientation, reduced libido, and impotency (affecting women as well as men).¹⁹

Medical intervention utilising the tools of high technology has also given rise to its own peculiar forms of iatrogenic diseases. Between the years 1942 and 1954 the problem of retrolental fibroplasia, disease of the eye leading to blindness, came to figure prominently in the management of premature infants in the United States. Despite being possessed of some of the most advanced medical technology available, hospital nurseries especially equipped to accommodate premature babies were finding that around 90% of all low-weight infants suffered either partial or total blindness. Indeed by 1954 retrolental fibroplasia ranked first in the United States among the causes of blindness in children.²⁰ Investigations eventually showed that the increasing incidence of the disease paralleled the introduction of plastic incubators into which high concentrations of oxygen were pumped to the premature infants on the assumption that oxygen therapy was beneficial, an assumption which, during the time high-concentration oxygen

therapy was used, was in fact untested. Oxygen therapy did make the babies look pink, but definitive evidence was provided in 1954 by Lanman et. al. that it also made them go blind.²¹

Another example of the extent to which high-technology medicine can be debilitating is amply demonstrated by the controversy surrounding coronary arteriography, a test technique whereby a dye is injected into the coronary arteries by way of a small catheter threaded from one of the blood vessels in the limbs and back towards the heart. The technique is designed to assist in the diagnosis and evaluation of coronary heart disease by providing an outline of the interior of the coronary arteries through the medium of the passage of the dye which is visible on X-ray film. In support of the procedure, mortality rates of 0.1% or one per thousand are cited to indicate the technique to be relatively innocuous. Taylor has commented, however, that the statistics belie the true state of affairs.

The mortality rate of one per thousand is accurate, he says, if the statistical analysis is restricted to results of the procedure deriving from only "very competent" and "experienced" units which perform it. Surveys of the technique which reflect a regional and more comprehensive base reveal practice of coronary arteriography was carried out, it showed that the mortality rate was not one per thousand, but virtually one in every hundred, ten times the rate regarded as innocuous. The death rate for patients undergoing the procedure in some institutions was as high as 8%. The incidence of cardiac arrest during the procedure, is in respect of which defibrillation was required to resuscitate the heart, ranged from 1-10%. Some studies report that in addition to the threat of mortality, serious complications resulting for coronary arteriography are of the order of 1.5%.²²

X-rays represent another dimension of high-technology medicine whose unbridled use has led to untold iatrogenic illness and disease. Mendelsohn reports that thyroid lesions, a considerable number of which are proving to be cancerous, "are turning up by the thousands in people who were exposed to head, neck, and upper chest radiation twenty to thirty years ago."²³ The amount of radiation required to cause thyroid cancer, he asserts, is "less than that produced by ten lite-wing dental X-rays."²⁴ **It is sobering to hear that every year some 4,000 people die from radioactive dental and medical interventionist techniques, and there are those who urge that the estimate is conservative.**²⁵ The use of X-rays to diagnose and assess the female breast is - despite the iatrogenic problems associated with them -widely recommended as an effective means of detecting breast cancer in its early stages. Setting aside the fact that studies have shown that disagreement among radiologists is considerable in respect of their interpretation of the same film, it is even more distressing to find other studies reporting that mammography will in fact cause more breast cancer than it will detect and that the number of deaths from breast cancer caused by mammography may in fact "balance the number of patients who may be cured by early diagnosis and treatment of the naturally occurring disease."²⁶ Putting aside the cancer-causing effects of mammography, the efficacy of the procedure in correctly diagnosing cancer can be questioned. At on Australian teaching

hospital between 1979 and 1988, 218 women attended for mammography, in 95 of which cases the mammogram failed to detect breast cancer. For 47 of these delayed treatment had tragic results.²⁷

Specific iatrogenic diseases resulting from surgical intervention are astronomical in number and kind. Complications arise from lack of surgical expertise, the degree of difficulty involved in performing the surgery, the unique constitution of the patient, anaesthetic accidents, laceration of large blood vessels, and misplace ligatures disrupting nerve responses, blood flow, etc. Taylor reports that an untold variety of surgical instruments, swabs, etc. have been left and sutured to cause serious infection. Even the talc commonly used by surgeons to lubricate their hands so that their surgical gloves can be more easily fitted is now known to cause inflammatory reactions in patients on whom they operate. Uncontrollable internal bleeding, shock, coma, and death are not uncommon side effects of surgical intervention.²⁸

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